MARKET CONDUCT EXAMINATION REPORT
Dated September 27, 2012

COVERING THE TIME PERIOD OF JANUARY 1, 2009 THROUGH DECEMBER 31, 2009

ROCKY MOUNTAIN HEALTHCARE OPTIONS, INC.
2775 Crossroads Blvd., PO Box 10600
Grand Junction, CO 81502-5600

NAIC Company Code 47004
NAIC Group Code 1184

CONDUCTED BY:

COLORADO DIVISION OF INSURANCE

ROCKY MOUNTAIN HEALTHCARE OPTIONS, INC.

MARKET CONDUCT
EXAMINATION REPORT
Dated September 27, 2012

COVERING THE TIME PERIOD OF JANUARY 1, 2009 THROUGH DECEMBER 31, 2009

Examination Performed by:

State Market Conduct Examiners

Jeffory A. Olson, CIE, MCM, FLMI, AIRC, ALHC
Examiner-in-Charge

Violetta R. Pinkerton, CIE, MCM, CPCU, CPIW
Lead On-site Examiner

Damion Hughes

And

Independent Contract Examiners

Larry E. Cross, CIE

Jay E. Hodges, CIE, ALHC, HIA

Yvonne Sainsbury, AIE

TABLE OF CONTENTS

COMPANY PROFILE

The following profile is based on information provided by Rocky Mountain HealthCare Options, Inc. and has not been independently verified by the Division of Insurance:

Rocky Mountain HealthCare Options, Inc. (Rocky Mountain HCO) is a Colorado nonprofit corporation with a certificate of authority to operate as a nonprofit hospital, medical-surgical and health service corporation. Rocky Mountain Health Maintenance Organization, Inc. is the sole member of Rocky Mountain HCO. Rocky Mountain HCO obtained its certificate of authority and began operations on May 28, 1993.

Rocky Mountain HCO provides medical benefit plans and services to more than 36,250 commercial members. The organization offers a wide range of medical benefit options including PPO large and small group plans, individual plans, and high deductible health benefit plans for health savings accounts (HSAs). Through its offerings, Rocky Mountain HCO serves a broad cross section of Coloradans.

Operations

Rocky Mountain HCO operates only in Colorado. Headquarters are located in Grand Junction, Colorado. The company is certified to operate in all Colorado counties. The organization has branch offices in Denver, Pueblo and Durango. Accounting records are maintained in the corporate office in Grand Junction, Colorado.

Rocky Mountain HCO provides health care benefits to large and small employer groups and individuals. The company contracts with individual physicians, physician groups and physician practice association, hospitals and the health care providers to provide health care services to its members.

In Western Colorado, the plan's founding geographical location; more than 90 percent of the physicians in most service areas participate with Rocky Mountain HCO. Nearly every hospital in the Western Slope service area participates. Statewide, Rocky Mountain HCO contracts with approximately 8,140 primary care and specialty physicians, 3,800 non-physician specialty providers, 99 hospitals, 520 outpatient facilities, and 860 pharmacies.

Organization Structure

Rocky Mountain HCO's operations are directed by a community Board of Directors selected by Rocky Mountain Health Maintenance Organization. Rocky Mountain Health Maintenance Organization, Inc. is the sole member of Rocky Mountain HCO.

A relational chart and description are included below, along with an organizational chart detailing the levels of management and reporting structure.

Description of Relational Chart

Rocky Mountain Health Maintenance Organization, Inc.
Colorado Non-Profit Organization – FEIN 84-0614905
NAIC Code 95482
State of Domicile – Colorado

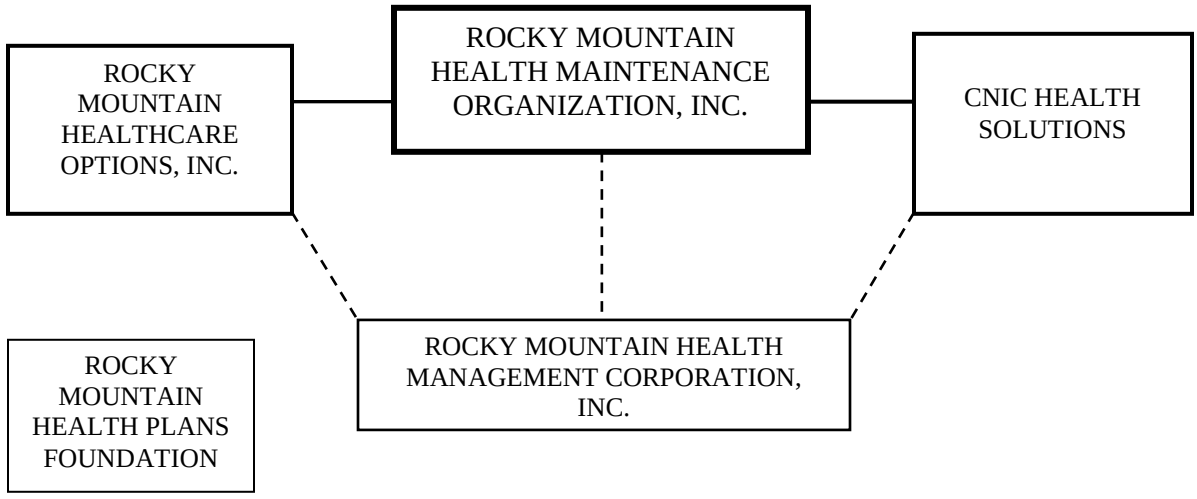
Rocky Mountain HealthCare Options, Inc.
Colorado Non-Profit Hospital, Medical/Surgical and Health Service Corporation – FEIN 84-1224718
NAIC Code 47004
State of Domicile – Colorado

Rocky Mountain Health Maintenance Organization, Inc. is the only member of Rocky Mountain HealthCare Options, Inc.

CNIC Health Solutions, Inc.
Colorado Corporation – FEIN 71-0873411

Rocky Mountain Health Maintenance Organization, Inc. owns 100% of the outstanding stock of CNIC Health Solutions, Inc.

ORGANIZATIONAL CHART



Ownership ——
Contractual Relationship - - - - - -

The following shows Rocky Mountain HCO's written premium and market share for the period under examination:

Premium and Market Share as of December 31, 2009:

Individual:	$21,943,097*
Small Group:	$44,729,347*
Large Group:	$35,761,663*
Total Written Premium:	$102,434,108*
Total Accident and Health Insurance /Health Benefit Plan Market Share:	1.08%**

* As reported by Rocky Mountain HCO
**As shown in the 2009 Edition of the Colorado Insurance Industry Statistical Report

PURPOSE AND SCOPE

State market conduct examiners with the Colorado Division of Insurance ("Division"), who were assisted by independent contract examiners, reviewed certain business practices of Rocky Mountain HealthCare Options, Inc. ("Rocky Mountain HCO" or "Company"). This market conduct examination (MCE) was conducted in accordance with Colorado insurance laws, §§ 10-1-203, 10-1-204, 10-1-205, as well as § 10-3-1106, C.R.S., which empower the Commissioner of Insurance ("Commissioner") to examine any entity engaged in the business of insurance in the State of Colorado.

The purpose of this examination was to determine Rocky Mountain HCO's compliance with Colorado laws related to nonprofit hospital, medical – surgical, and health service corporations. Examination information contained in this report will serve only this purpose except as provided by law pursuant to §§ 10-1-204 and 205, C.R.S. The findings and conclusions, including the Final Agency Order, arising out of this examination shall be public record.

The examiners conducted the examination in accordance with procedures developed by the Division, based on model procedures developed by the National Association of Insurance Commissioners ("NAIC"). They relied primarily on records and materials maintained and/or supplied by Rocky Mountain HCO. The MCE covered the period from January 1, 2009, through December 31, 2009.

The examination included review of the following:

Company Operations and Management
Complaints
Producers
Forms
Rating
New Business Applications and Renewals
Cancellations/Declinations/Non-Renewals/Rescissions
Claims
Utilization Review

The examination report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for Rocky Mountain HCO identifying any concerns and/or discrepancies. The comment forms contained a section that permitted Rocky Mountain HCO to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to health insurance laws as they pertained to nonprofit hospital, medical – surgical, and health service corporations. Examination findings may result in administrative action by the Division. The examiners may not have discovered all unacceptable or non-complying practices of Rocky Mountain HCO. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company, nonprofit hospital, medical – surgical and health service corporation or insurance company product.

METHODOLOGY

The examiners reviewed Rocky Mountain HCO's business practices concurrently with an examination of Rocky Mountain Health Maintenance Organization, Inc. ("Rocky Mountain HMO").

At the beginning of the examination, the examiners met with the Company examination coordinator to discuss the examination process. One of the topics discussed was that although Rocky Mountain HCO and Rocky Mountain HMO are separate companies, there are certain policies, procedures and data systems that are common to both companies.

Therefore, it was agreed that in cases involving claims, utilization review, and some underwriting processes, the Division would "deem" the findings applicable to both companies, even though the actual findings may have been identified in Rocky Mountain HMO data. The examiners followed this "deeming" process throughout the examination for Rocky Mountain HCO except for two areas:

- Rocky Mountain HCO's individual new business and renewals, declinations, rescissions, , nonrenewals and cancellations, and

- Rocky Mountain HCO's contract forms, some of which, but not all, were different from Rocky Mountain HMO's contract forms.

Rocky Mountain HMO was not actively marketing individual health plans during the examination period. The examiners reviewed Rocky Mountain HCO's individual new business applications, underwriting records, contract forms and other forms and applied the findings only to Rocky Mountain HCO.

The examiners reviewed Rocky Mountain HCO's business practices, as described above, to determine compliance with Colorado insurance law applicable to nonprofit hospital, medical – surgical, and health service corporations as outlined below.

Statute or Regulation	Subject
Section 10-1-128, C.R.S.	Fraudulent insurance acts - immunity for furnishing information relating to suspected insurance fraud - legislative declaration.
Section 10-2-401, C.R.S.	License required.
Section 10-2-702, C.R.S.	Commissions.
Section 10-3-1104, C.R.S.	Unfair methods of competition and unfair or deceptive acts or practices.
Section 10-16-102, C.R.S.	Definitions.
Section 10-16-103.5, C.R.S.	Payment of premiums – required term in contract.
Section 10-16-104, C.R.S.	Mandatory coverage provisions – definitions.
Section 10-16-104.3, C.R.S.	Dependent health coverage for persons under twenty-five years of age – coverage for students who take medical leave of absence.
Section 10-16-104.5, C.R.S.	Autism – treatment – not mental illness.
Section 10-16-104.7, C.R.S.	Substance abuse - court-ordered treatment coverage.
Section 10-16-104.8, C.R.S.	Mental health services coverage - court-ordered.
Section 10-16-105, C.R.S.	Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic health benefit plans - rules - benefit design advisory committee - repeal.
Section 10-16-105.2, C.R.S.	Small employer health insurance availability program.
Section10-16-105.5, C.R.S	Individual health plans – federally eligible individuals – limited guarantee issue.
Section 10-16-106.5, C.R.S.	Prompt payment of claims – legislative declaration.

Section 10-16-106.7, C.R.S.	Assignment of health insurance benefits.
Section 10-16-107, C.R.S.	Rate regulation – rules – approval of policy forms – benefit certificates – evidences of coverage – benefits ratio – disclosures on treatment of intractable pain.
Section 10-16-107.2, C.R.S.	Filing of health policies.
Section 10-16-108, C.R.S.	Conversion and continuation privileges.
Section 10-16-108.3, C.R.S.	Continuation privilege – special election period – notice requirements – definitions - repeal.
Section 10-16-108.5, C.R.S.	Fair marketing standards.
Section 10-16-109, C.R.S.	Rules and regulations.
Section 10-16-112, C.R.S.	Private utilization review – health care coverage entity responsibility.
Section 10-16-113, C.R.S.	Procedure for denial of benefits – internal review - rules.
Section 10-16-113.5, C.R.S.	Independent external review of benefit denials – legislative declaration – definitions.
Section 10-16-118, C.R.S.	Limitations on preexisting condition limitations.
Section 10-16-121, C.R.S.	Required contract provisions in contracts between carrier and providers.
Section 10-16-125, C.R.S.	Reimbursement to nurses.
Section 10-16-201.5, C.R.S.	Renewability of health benefit plans – modifications of health benefit plans.
Section 10-16-316, C.R.S.	Complaints.
Section 10-16-317.5, C.R.S.	Assignment of benefits.
Section 10-16-704, C.R.S.	Network adequacy – rules – legislative declaration – repeal.
Section 10-16-705, C.R.S.	Requirements for carriers and participating providers.
Section 10-16-706, C.R.S.	Intermediaries.
Insurance Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-owned Private Passenger Automobile-Type Endorsement Forms, Claims-made Liability Forms and Preneed Funeral Contracts and Excess Loss Insurance in Conjunction with Self-Insured Employer Benefit Plans under the Federal "Employee Retirement Income Security Act"
Insurance Regulation 1-1-7	Market Conduct Record Retention
Insurance Regulation 1-1-8	Penalties and Timelines Concerning Division Inquiries and Document Requests
Insurance Regulation 4-2-1	Replacement of Individual Accident and Sickness Insurance.
Insurance Regulation 4-2-6	Concerning the Definition of the Term "Complications Of Pregnancy"
Insurance Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Insurance Regulation 4-2-9	Concerning Non-Discriminatory Treatment Of Acquired Immune Deficiency Syndrome (AIDS) And Human Immunodeficiency Virus (HIV) Related Illness by Life and Health Carriers
Insurance Regulation 4-2-11	Rate Filing Submissions For Health Insurance
Insurance Regulation 4-2-13	Mammography Minimum Benefit Level
Insurance Regulation 4-2-15	Required Provisions in Carrier Contracts with Providers, Carrier Contracts with Intermediaries Negotiating on Behalf of Providers, and Carrier Contracts with Intermediaries Conducting Utilization Reviews
Insurance Regulation 4-2-16	Women's Access to Obstetricians, Gynecologists And Certified Nurse Midwives under Managed Care Plans
Insurance Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits

Insurance Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-Existing Conditions
Insurance Regulation 4-2-19	Concerning Individual Health Benefit Plans Issued to Self-Employed Business Groups of One
Insurance Regulation 4-2-20	Concerning the Colorado Comprehensive Health Benefit Plan Description Form
Insurance Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Insurance Regulation 4-2-24	Concerning Clean Claim Requirements for Health Carriers
Insurance Regulation 4-2-27	Procedures for Reasonable Modifications to Individual and Small Group Health Benefit Plans
Insurance Regulation 4-2-28	Concerning the Payment of Early Intervention Services for Children Eligible for Benefits Under Part C of the Federal "Individuals With Disabilities Education Act"
Insurance Regulation 4-2-30	Concerning Rules for Complying with Mandated Coverage of Hearing Aids and Prosthetics
Insurance Regulation 4-6-2	Group Coordination Of Benefits
Insurance Regulation 4-6-3	Concerning CoverColorado Standardized Notice Form and Eligibility Requirements
Emergency Regulation 08-E-12 (1-1-09)	Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans
Insurance Regulation 4-6-5 (2-1-09)	Concerning Small Employer Group Health Benefit Plans and the Basic and Standard Health Benefit Plans
Insurance Regulation 4-6-7	Concerning Premium Rate Setting for Small Group Health Plans
Insurance Regulation 4-6-8	Concerning Small Employer Health Plans
Insurance Regulation 4-6-9	Concerning Conversion Coverage
Insurance Regulation 4-6-12	Mandatory Coverage of Mental Illnesses Pursuant to § 10-16-104(5) and (5.5), C.R.S., for Small Group Policies.
Insurance Regulation 6-2-1	Complaint Records Maintenance

Prior Examinations

Rocky Mountain HCO was the subject of a previous market conduct examination which included a report dated March 24, 2006, for the time period of January 1, 2004, through December 31, 2004.

Sampling Methodology

Rocky Mountain HCO provided unique underwriting populations for individual new business and renewals, declinations, rescissions, nonrenewals and cancellations only. All findings for group underwriting, as well as for claims and utilization review, were "deemed" from the review of Rocky Mountain HMO data as indicated earlier in this report. The examiners used ACL™ software to select random samples from each of those unique populations for review in accordance with the sampling methodology and sample sizes as set forth in the 2010 NAIC Market Regulation Handbook (Handbook).

An error tolerance level of seven percent (7%) for claims and ten percent (10%) for other areas was established per the Handbook to determine reportable exceptions.

An error tolerance of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance was applied to identify possible system errors.

Company Operations and Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, claims and underwriting guidelines/procedures, and timely cooperation with the examination process.

Complaints

The examiners reviewed the records of complaints received by Rocky Mountain HCO and compared those records with the Division's records to verify accuracy in maintaining complaint records.

Producers

The examiners reviewed the licensing status of the submitting producers for the samples of the files selected in the new business applications and renewal sections of the examination for compliance with the appropriate Colorado statutes and regulations.

Forms

The examiners reviewed the forms used in the Company business practices as well as the following contract forms, endorsements, and disclosure forms in use during the exam period for compliance with Colorado insurance law:

Form Name	Form Number	Edition Date
SOLO SELECT PPO HEALTH BENEFITS CONTRACT	HCO-2009-SOLOSELECT-I-HBC-01-109	2009
SOLO SELECT PPO HEALTH BENEFITS CONTRACT – COVERAGE SCHEDULE	HCO-2009-SOLOSELECT-I-CS/2500D/3000M-01-109	01/2009
SOLO SELECT PPO HEALTH BENEFITS CONTRACT – COVERAGE SCHEDULE	HCO-2009-SOLOSELECT-I-CS/2500D/3000M-02-709	07/2009
AMENDMENT TO SOLO HEALTH BENEFITS CONTRACT	HCO-2009-SOLOSELECT/HDHP-I-AMEND-01-109	01/2009
AMENDMENT TO SOLO HEALTH BENEFITS CONTRACT & EVIDENCE OF COVERAGE	HCO-2009-SOLO-I-AMEND/CC-01-709	07/2009
AMENDMENT TO SOLO SELECT PPO HEALTH BENEFITS CONTRACT & EVIDENCE OF COVERAGE	HCO-2009-SOLO/SELECT-I-AMEND-01-1109	11/2009

HEALTH BENEFITS CONTRACT PRESCRIPTION DRUG SUPPLEMENT	HCO-2006-SOLO-I-RX10G/ND-01-706	2006
HEALTH BENEFITS CONTRACT PRESCRIPTION DRUG SUPPLEMENT	HCO-2006-SOLO-I-RX10/40/60-01-706	2006
SOLO HEALTH BENEFITS CONTRACT - MATERNITY SERVICES SUPPLEMENT	HCO-2004-SOLO-I-MSS-01-104	2004
SOLO Change Form	MK509R0209	2009
SOLO Billing Change Form	MK246R0209	2009
SOLO Health Care Plan Change Form	MK244-R0309	2009
ROCKY MOUNTAIN VISTA PREFERRED PROVIDER ORGANIZATION LIMITATIONS AND EXCLUSIONS	L&E-RM Vista PPO-709	2009
ROCKY MOUNTAIN VISTA PREFERRED PROVIDER ORGANIZATION EVIDENCE OF COVERAGE	HCO-2009-VISTAPPO-G-EOC-01-709	2009
ROCKY MOUNTAIN VISTA PPO 1000/70 PLAN EVIDENCE OF COVERAGE	HCO-2009-VISTAPPO-G-CS/1000/70-01-709	2009
AMENDMENT TO ROCKY MOUNTAIN VISTA PPO EVIDENCE OF COVERAGE	HCO-2009-VISTA/PPO-SG-AMEND-01-1109	11/2009
HEALTH BENEFITS CONTRACT & EVIDENCE OF COVERAGE PRESCRIPTION DRUG SUPPLEMENT	HCO-2009-ALL-G-RX/15/40/55-01-809	2009
PPO BASIC LIMITED MANDATE HEALTH BENEFIT PLAN FOR COLORADO LIMITATIONS AND EXCLUSIONS	L&E-PPOBasic-109	2009
PPO BASIC LIMITED MANDATE HEALTH BENEFIT PLAN FOR COLORADO ADDITIONAL BENEFIT SUPPLEMENT	HCO-2008-BAS-G-ABS-01-108	2008

PPO BASIC LIMITED MANDATE HEALTH BENEFIT PLAN FOR COLORADO HEALTH BENEFITS CONTRACT	HCO-2009-BAS-G-HBC-01-109	2009
PPO BASIC LIMITED MANDATE HEALTH BENEFIT PLAN FOR COLORADO COVERAGE SCHEDULE	HCO-2009-BAS-G-HBC-01-109	2009
AMENDMENT TO PPO BASIC LIMITED MANDATE HEALTH BENEFIT PLAN FOR COLORADO	HCO-2009-BAS-G-AMEND-01-109	01/2009
PPO STANDARD HEALTH BENEFIT PLAN FOR COLORADO LIMITATIONS AND EXCLUSIONS	L&E-PPOStandard-109	2009
PPO STANDARD HEALTH BENEFIT PLAN FOR COLORADO HEALTH BENEFITS CONTRACT	HCO-2009-STD-G-HBC-01-109	2009
PPO STANDARD HEALTH BENEFIT PLAN FOR COLORADO COVERAGE SCHEDULE	HCO-2009-STD-G-HBC-01-109	2009
AMENDMENT TO PPO STANDARD HEALTH BENEFIT PLAN FOR COLORADO	HCO-2009-STD-G-AMEND-01-109	2009
PPO STANDARD HEALTH BENEFIT PLAN FOR COLORADO SUPPLEMENTAL BENEFIT ENDORSEMENT	HCO-2006-STD-G-SUPPBEN-01-106	2006
Supplemental Coverage for Alcohol Rehabilitation for Small Groups	MK164-R0209	2009
Offer for Alcoholism Rehabilitation Supplemental Benefit	MK177-R0209	2009
PPO Basic Limited Mandate Health Benefit Plan for Colorado Supplemental Coverage	Mk291-R0209	2009
PPO Basic Limited Mandate Health Benefit Plan for Colorado Offer of Supplemental Coverage	MK403-R0209	2009

ROCKY MOUNTAIN GOOD HEALTH PREFERRED PROVIDER ORGANIZATION HEALTH BENEFITS CONTRACT	HCO-2009-GH/PPO-G-HBC-01-109	2009
SOLO Health Plan Application	MK14 R0209	2009
SOLO Health Plan Application - Spanish	MK14-S-R0209	2009
SOLO Individual Disenrollment Form	MK508R0209	2009
Application for Health Benefits For Groups with 2 or More Employees	MK69-R0209	2009
Application for Health Benefits For Groups with 2 or More Employees - Spanish	MK69-S-R0209	2009
Attestation for Business Group of One	MK73R0209	2009
Group Change Form	MK158-R0409	2009
Application for Conversion Coverage	MK181-R0209	2009
Open Enrollment Certification for Business Group of One	MK199-R0209	2009
Notice to Rocky Mountain Health Plans of Qualifying Event for Continuation of Coverage	MK210-R0209	2009
Request For Coverage For a Physically or Mentally Disabled Dependent Child	MK222-0209	2009
Group Disenrollment Form	MK231-R0209	2009
Employee Disenrollment Form	MK231-R0409	2009
Uniform Employee Application	MK453-R0209	2009
Uniform Employee Application – Spanish	MK453S-R0209	2009
Request for Enrollment of Common-Law Spouse	MK460-R0209	2009
Disclosure Notice for Small Employer Groups	MK57-R0209	2009

The contract forms were also reviewed for inclusion on the annual certified listing of forms filed with the Division for the period under review.

Rating

Rocky Mountain HMO provided copies of its rate filings with the Division for the period under examination. The examiners selected random samples, reviewed and rated policies from the populations of health benefit plans issued and renewed during the examination period. The examiners compared the rates determined in that process with the rates Rocky Mountain HMO showed in the files to determine accuracy, compliance with the filings and compliance with Colorado insurance laws. The findings were "deemed" to apply to Rocky Mountain HCO.

New Business Applications and Renewals

For the period under examination, the examiners selected a random sample of newly issued health benefit plans and renewals and reviewed them to determine compliance with Colorado insurance laws. Group samples were selected and reviewed from Rocky Mountain HMO and "deemed" to apply to Rocky Mountain HCO. The examiners selected a random sample of individual files from the population of newly issued individual health benefit plans and renewals for review from Rocky Mountain HCO data.

Cancellations, Declinations, NonRenewals, Rescissions

The examiners selected a random sample of cancelled or non-renewed group files from a single population of cancelled and non-renewed policies from Rocky Mountain HMO data. The findings after review for compliance with contractual obligations and Colorado insurance law were "deemed" to Rocky Mountain HCO.

There was no "deeming" for individual underwriting. The examiners selected and reviewed a random sample from a single population of individual cancellations and nonrenewals from Rocky Mountain HCO data. The examiners also selected a random sample from the population of individual plan declinations in Rocky Mountain HCO data and reviewed the entire Rocky Mountain HCO population of twelve (12) individual plan rescissions.

Claims

To determine compliance with Colorado insurance law regarding timely payment of claims, the appropriate investigation and resolution of claims, accurate payment and correct notifications of payments and denials to members and providers, the examiners selected a random sample of claims from each of five (5) Rocky Mountain HMO populations:

- Paid claims;
- Denied claims;
- Electronic claims paid, denied or settled more than thirty (30) days after receipt;
- Non-electronic claims paid, denied or settled more than forty-five (45) days after receipt; and
- All claims paid, denied or settled more than ninety (90) days after receipt.

For those claims that were adjusted after the initial adjudication of the claim, regardless of whether the randomly selected sample claim was the original claim or an adjusted version of the claim, the examiners reviewed all versions of the claim to determine whether Rocky Mountain HMO errors in processing caused the claim to be resolved late when finally adjudicated.

The findings from review of the five (5) claims samples were "deemed" to apply to Rocky Mountain HCO.

Utilization Review

The examiners reviewed Rocky Mountain HMO's utilization management program including policies and procedures. The examiners selected a random sample from the approved and denied utilization review populations and reviewed the entire population of fifteen (15) utilization review appeals for compliance with Colorado insurance law. The findings from these reviews were "deemed" to apply to Rocky Mountain HCO.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of twelve (12) findings in which Rocky Mountain HCO was not in compliance with Colorado statutes and regulations. The following is a summary of the examiners' findings.

Operations and Management: In the area of operations and management, the examiners identified one (1) issue of concern:

Issue A1: Failure to ensure that all forms certified and used by Rocky Mountain HCO during the examination period were in compliance with Colorado insurance law.

Complaints: In the area of complaints, no compliance issues were identified that met the reporting threshold to be included in this report.

Producers: In the area of producers, no compliance issues were identified that met the reporting threshold to be included in this report.

Forms: In the area of forms, the examiners identified four (4) issues of concern:

Issue E1: Failure of the Company's certificate of creditable coverage forms, in some instances, to include required information. *(This was a partial repeat of prior issue H2 in the findings of the market conduct examination report for 2004).*

Issue E2: Failure of the Company's basic and standard health benefit plan forms, in some instances, to include the required "Family Planning Service" benefit for treatment and screening of sexually transmitted diseases within the schedule of health care services.

Issue E3: Failure of the Company's forms, in some instances, to include the mandatory coverage provisions related to a hospital stay for dependent newborn children following birth.

Issue E4: Failure of the Rocky Mountain HCO's forms, in some instances, to include all the required hospice care service benefits and provisions.

Rating: In the area of rating, no compliance issues were identified that met the reporting threshold to be included in this report.

New Business Applications and Renewals: In the area of new business applications and renewals, the examiners identified one (1) issue of concern:

Issue G1: Failure to require applicants for individual coverage to complete the determination of self-employed business groups of one and to provide disclosure forms with required information to these applicants.

Cancellations, Declinations, Non-Renewals, Rescissions: In the area of cancellations, declinations, nonrenewals, and rescissions, no compliance issues were identified that met the reporting threshold to be included in this report.

Claims: In the area of claims, the examiners identified five (5) issues of concern from the review of Rocky Mountain HMO data which were "deemed" to apply to Rocky Mountain HCO:

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.

Issue J2: Failure, in some cases, to pay interest or penalty owed on claims not paid, denied or settled timely, as required by Colorado insurance law.

Issue J3: Failure, in some cases, to comply with Colorado insurance law regarding written explanations of what additional information is needed to determine liability and adjudicate a claim.

Issue J4: Failure to adopt and implement reasonable standards for prompt investigation of claims including refusing to pay claims or retracting claims payments without conducting a reasonable investigation of all available information.

Issue J5: Failure to correctly count the number of days to pay or deny claims and determine whether the claim was adjudicated late and/or interest was owed.

Utilization Review: In the area of utilization review, the examiners identified one (1) issue of concern from the review of Rocky Mountain HMO data which was "deemed" to apply to Rocky Mountain HCO:

Issue K1: Failure to include the qualifying credentials of the physician or clinical peer who evaluated the appeal in the written notification of the decision.

FACTUAL FINDINGS

COMPANY OPERATIONS AND MANAGEMENT

Issue A1: Failure to ensure that all forms certified and used by Rocky Mountain HCO during the examination period were in compliance with Colorado insurance law.

Section 10-3-1104, C.R.S., –Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> . . .
>
> (s) *Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates.* Such solicitation or certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108, and 10-3-1109. [Emphasis added.]

Section 10-16-107.2, C.R.S., Filing of health policies - rules, states in part:

> (1) All sickness and accident insurers, health maintenance organizations, and nonprofit hospital and health service corporations authorized by the commissioner to conduct business in Colorado shall submit an annual report to the commissioner listing any policy form, endorsement, or rider for any sickness, accident, nonprofit hospital and health service corporation, health maintenance organization, or other health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado. *Such listing* shall be submitted by January 15, 1993, and not later than December 31 of each subsequent year and *shall contain a certification by an officer of the organization that each policy form, endorsement, or rider in use complies with Colorado law*. The necessary elements of the certification shall be determined by the commissioner. [Emphases added.]

Rocky Mountain HCO was not in compliance with Colorado insurance law in that not all forms certified and used by Rocky Mountain HCO during the examination period included all mandated benefits or limits as evidenced by issues E2 through E4 in this report.

Form Name	Form Number	Edition Date
ROCKY MOUNTAIN VISTA PREFERRED PROVIDER ORGANIZATION EVIDENCE OF COVERAGE	HCO-2009-VISTAPPO-G-EOC-01-709	2009
PPO BASIC LIMITED MANDATE HEALTH BENEFIT PLAN FOR COLORADO	HCO-2009-BAS-G-HBC-01-109	2009
PPO STANDARD HEALTH BENEFIT PLAN FOR COLORADO	HCO-2009-STD-G-HBC-01-109	2009

SOLO SELECT PPO HEALTH BENEFITS CONTRACT	HCO-2009-SOLOSELECT-I-HBC-01-109	2009

Recommendation No. 1:

Rocky Mountain HCO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of §§ 10-3-1104 and 10-16-107.2, C.R.S., during the examination period. In the event Rocky Mountain HCO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HCO shall be required within thirty (30) days from the date this report is adopted to provide written evidence to the Division that it has revised and put in use procedures to ensure that all contract forms certified are in compliance with Colorado insurance law.

FORMS

Issue E1: Failure of the Company's certificate of creditable coverage forms, in some instances, to include required information. ***(This was a partial repeat of prior issue H2 in the findings of the market conduct examination report for 2004).***

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states in part:

(1) A health coverage plan that covers residents of this state:

(a) (I) If it is a group health benefit plan, shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than six months following the date of enrollment of the individual in such plan, or if earlier, the first day of the waiting period for such enrollment; except that, for business groups of one, a health benefit plan shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than twelve months following the date of enrollment of the individual in such plan. *A group health benefit plan may impose a preexisting condition exclusion or limitation only if such exclusion relates to a condition* (whether physical or mental), regardless of the cause of the condition, *for which medical advice, diagnosis, care, or treatment was recommended or received within six months immediately preceding the date of enrollment* of the individual in such plan, or if earlier, the first day of the waiting period for such enrollment; except that a group health benefit plan shall not impose any preexisting condition exclusion in the case of a child that is adopted or placed for adoption before attaining eighteen years of age, or relating to pregnancy.

. . .

(b) *Shall waive* any affiliation period or time period applicable to *a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage*. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. This paragraph (b) shall not preclude application of any waiting period applicable to all new enrollees under the plan. *The method of crediting and certifying coverage shall be determined by the commissioner by rule.* [Emphases added.]

Colorado Insurance Regulation 4-2-18, promulgated under the authority of Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states in part:

. . .

Section 4 Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. *For plans subject to the*

jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days. [Emphasis added.]

Section 5 Rules

A. Application of federal laws concerning creditable coverage.

1. *The method for crediting and certifying creditable coverage* for the purposes of limiting pre-existing condition exclusion periods, as required by Section 10-16-118(1)(b), C.R.S., *shall be as set forth in the federal regulations incorporated below*.

2. Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, *Colorado law shall prevail*.

3. *The following sections of the federal regulations,* adopted by the U.S. Department of Health and Human Services, are hereby incorporated by reference and *shall have the force of Colorado law*, in accordance with Section 24-4-103(12.5), C.R.S.:

45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; and 45 C.F.R. 148.124(b). *These sections concern the method for counting creditable coverage; requirements for providing certificates of creditable coverage* to those who were insured under group plans, *including the form and content of the certificates;* and requirements for providing certificates of creditable coverage to those who were insured under individual plans, *including the form and content of the certificates*.

B. Colorado law concerning creditable coverage.

. . .

4. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, *any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation.* [Emphases added.]

45 C.F.R. 146.115, Certification and disclosure of previous coverage, states in part:

(a) Certificate of creditable coverage –

. . .

(3) Form and content of certificate –

. . .

(ii) Required information. The certificate must include all of the following -

. . .

(F) Either –

(*1*) *A statement that an individual has at least 18 months* (for this purpose, 546 days is deemed to be 18 months) *of creditable coverage, disregarding days of creditable coverage before a significant break in coverage*, or [Emphases added.]

45 C.F.R. 148.124, Certification and disclosure of coverage, states in part:

. . .

(b) General Rules –

(1) Individuals for whom a certificate must be provided; timing of issuance.

. . .

(2) Form and content of certificate –

(i) Written certificate –

. . .

(ii) Required information. The certificate must include the following:

. . .

(E) Either one of the following:

(*1*) *A statement that the individual has at least 18 months* (for this purpose 546 days is deemed to be 18 months) *of creditable coverage, disregarding days of creditable coverage before a significant break in coverage* as defined in 45 CFR 146.113(b)(2)(iii)[Emphases added].

Colorado law requires that a carrier's certificate of creditable coverage must reflect that for plans subject to the jurisdiction of the Division, a significant break in coverage consists of more than ninety (90) consecutive days. This required definition must also clarify that for other plans (i.e., those not subject to the jurisdiction of the Division), a significant break in coverage may consist of as few as sixty-three (63) days.

Colorado insurance law defines a significant break in coverage as a period of consecutive days during all of which the individual did not have any creditable coverage. The period of consecutive days that constitutes a significant break in coverage is further defined as more than ninety (90) consecutive days.

Colorado insurance law provides that health benefit plans shall waive any limitation or exclusion of benefits due to an individual's preexisting condition if the individual had at least eighteen (18) months of continuous creditable coverage, disregarding days of creditable coverage before a significant break in coverage. Colorado insurance law incorporates provisions of 45 C.F.R. 146.115(a)(3), or 45 C.F.R. 148.124(b)(2), as appropriate.

Rocky Mountain HCO certificates of creditable coverage issued prior to October 31, 2009, were not in compliance with Colorado insurance law in that:

1. They did not include, in some instances, the required definition of a "significant break in coverage;"
2. They included, in some instances, a statement that a significant break in coverage was a time without coverage lasting ninety (90) days or more and referenced a 90-day break in coverage;

Rocky Mountain HCO's certificates of creditable coverage stated in part:

> . . .
>
> You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for *90 days or more* without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.
>
> > Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a *90-day break*. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan. [Emphases added.]

Form Name	Form Number	Edition Date
Certificate of Group Health Plan Coverage	EBM15R12/11/06	12/11/06
Certificate of Individual Health Plan Coverage	EBM15R12/11/06	12/11/06

Recommendation No. 2:

Rocky Mountain HCO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-118, C.R.S., and Colorado Insurance Regulation 4-2-18 during the examination period**.** In the event Rocky Mountain HCO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HCO shall be required within sixty (60) days from the date this report is adopted to provide written evidence to the Division that it has revised its certificate of creditable coverage form used for both individual and group plans to include the specific definition of "significant break in coverage" and correct information regarding what constitutes a "significant break in coverage. Within

these sixty (60) days, Rocky Mountain HCO shall also provide the Division with specimen copies of all forms containing the revised provisions and provide the proposed date the forms will be put in use.

In the market conduct examination for the period of January 1, 2004 through December 31, 2004, Rocky Mountain HCO was cited for failure to include all required information in its certificates of creditable coverage in compliance with Colorado insurance law. The violation resulted in Item #19 of Final Agency Order O-07-004 that indicated the Company should revise its procedures to ensure that any required language, including that of a significant break in coverage, was reflected in all issued certificates of creditable coverage in compliance with Colorado insurance law.

Issue E2: Failure of the Company's basic and standard health benefit plan forms, in some instances, to include the required "Family Planning Service" benefit for treatment and screening of sexually transmitted diseases within the schedule of health care services.

Colorado Regulation 4-6-5, Concerning Small Employer Group Health Benefit Plans and The Basic and Standard Health Benefit Plans, promulgated under the authority of §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., state in part:

. . .

Section 4 Rules*

A. Plans

1. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three plan design options as appended to this regulation and shall constitute the basic health benefit plan design pursuant to §10-16-105(7.2), C.R.S.* At least one of these three plan design options, two of which are high deductible, HSA-qualified plan options, shall be required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S., and as conversion coverage pursuant to §10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic health benefit plan or to those individuals purchasing a basic conversion plan.

2. Standard Plan. *The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer group market pursuant to §10-16-105(7.3), C.R.S.,* and for use as conversion coverage pursuant to §10-16-108, C.R.S. [Emphases added.]

BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance

Effective January 1, 2009

. . .

5. All basic and standard health benefit plans shall also comply with the following requirements:

*Colorado Emergency Insurance Regulation 08-E-12 was promulgated effective January 1, 2009 and Colorado Insurance Regulation 4-6-5 was amended effective February 1, 2009. The language in paragraphs 4, A., 1. and 2. of the amended regulation is identical to the language in paragraphs 4., A., 1. and 2. of the emergency regulation. The language of paragraph 5., G., in the BASIC AND STANDARD HEALTH BENEFIT PLAN POLICY REQUIREMENTS FOR THE STATE OF COLORADO as appended to each regulation is also identical.

. . .

G. Family Planning Services: Family planning services must be included as a covered benefit under both the basic and standard health benefit plans. At a minimum, family planning services shall include maternity care, prenatal and postnatal care and counseling, *treatment and screening as appropriate for sexually transmitted diseases*, sterilization, contraceptives, and contraception counseling. [Emphasis added.]

Rocky Mountain HCO was not in compliance with Colorado insurance law in that its basic and standard health benefit plan forms, in some cases, did not include complete benefits for family planning services as required by Colorado Emergency Regulation 08-E-12 and Colorado Insurance Regulation 4-6-5 during the examination period. Specifically, the coverage for treatment and screening for sexually transmitted diseases was not included as a family planning service benefit within the schedule of health care services. The general exclusion included in the contract forms cited below, which stated that any service, supply, or other item not provided as a health care service in the schedule of health care services were not considered covered benefits, created a conflict which could be interpreted to mean treatment and screening for sexually transmitted diseases were not considered covered benefits. Coverage for treatment and screening for sexually transmitted diseases must be specifically included as a family planning service benefit within the schedule of health care services to ensure the contract forms are in compliance with Colorado insurance law.

Rocky Mountain HCO's HCO-2009-BAS-G-HBC-01-109 and HCO-2009-STD-G-HBC-01-109 contract forms in use during the examination period stated, in part, (with minor variances) the following:

2. BENEFITS, LIMITATIONS AND EXCLUSIONS

. . .

B. Schedule of Health Care Services

. . .

(16) Maternity Care, Complications of Pregnancy, Family Planning, Infertility Services and Abortions

. . .

Family Planning and Sterilization Procedures: Family planning counseling, information on birth control, insertion of contraceptive devices, fitting of diaphragms, vasectomies and tubal ligations.

Infertility Services: Physician services consisting of medical advice and testing for infertility.

Abortions: Pre- and post-abortion counseling. Except if prohibited by applicable law, therapeutic and elective abortions.

C. Limitations and Exclusions

. . .

(2) General Exclusions

. . .

(g) Any *service, supply* or other item *not provided as a Health Care Service in the Schedule of Health Care Services.* [Emphasis added.]

Form Name	Form Number	Edition Date
PPO BASIC LIMITED MANDATE HEALTH BENEFIT PLAN FOR COLORADO	HCO-2009-BAS-G-HBC-01-109	2009
PPO STANDARD HEALTH BENEFIT PLAN FOR COLORADO	HCO-2009-STD-G-HBC-01-109	2009

Recommendation No. 3:

Rocky Mountain HCO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of Colorado Emergency Regulation 08-E-12 and Colorado Insurance Regulation 4-6-5 during the examination period**.** In the event Rocky Mountain HCO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HCO shall be required within sixty (60) days from the date this report is adopted to provide written evidence to the Division that it has revised its contract forms to include the treatment and screening for sexually transmitted diseases as a family planning service benefit within the schedule of healthcare services, to ensure the contract forms are in compliance with current Colorado insurance law. Within these sixty (60) days, Rocky Mountain HCO shall also provide the Division with specimen copies of all forms containing the revised provisions and provide the proposed date the forms will be put in use.

Issue E3: Failure of the Company's forms, in some instances, to include the mandatory coverage provisions related to a hospital stay for dependent newborn children following birth.

Section 10-16-104, C.R.S., Mandatory coverage provisions-definitions, states in part:

(1) Newborn Children

(a) *All* group and *individual* sickness and accident insurance policies and all *service or indemnity contracts issued by any entity subject to part 3* or 4 of this article shall provide coverage for a dependent newborn child of the insured or subscriber from the moment of birth.

(b)(I) *Coverage for a hospital stay for a newborn following a normal vaginal delivery shall not be limited to less than forty-eight hours.* If forty-eight hours following delivery falls after 8 p.m., coverage shall continue until 8 a.m. the following morning.

(II) *Coverage for a hospital stay for a newborn following a cesarean section shall not be limited to less than ninety-six hours*. If ninety-six hours following the cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning. [Emphases added.]

Rocky Mountain HCO was not in compliance with Colorado insurance law in that its SOLO Select PPO Health Benefits individual contract form did not include the length of a hospital stay for a newborn following either a normal vaginal delivery or a cesarean section. Rocky Mountain HCO's maternity services supplement form did include the specific length of a hospital stay for a newborn. Although the maternity supplement, when included with the contract, modified the individual contract form to comply with Colorado insurance law, the form was optional. During the examination period, the maternity services supplement form was included only if purchased for an additional premium. Coverage for the specific length of a hospital stay for a newborn was a mandated coverage provision.

Rocky Mountain HCO's HCO-2009-SOLOSELECT-I-HBC-01-109 contract form in use during the examination period stated, in part the following:

2. BENEFITS, LIMITATIONS AND EXCLUSIONS

. . .

B. Schedule of Health Care Services

. . .

(21) Maternity Care and Complications of Pregnancy

Maternity Care: *Maternity Services are provided as described in the Maternity Services Supplement, if included with this Contract.* [Emphasis added.]

. . .

(24) Newborn Care

Services for treatment of injury and sickness for the first thirty-one (31) days of the newborn Dependent Child's life, provided that this Contract remains in effect during such thirty-one (31) day period. These services include Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. These services are available regardless of any limitations and exclusions with respect to medical conditions and procedures that are Health Care Services under this Contract, subject to any applicable Deductibles, Copayments, Coinsurance, Maximum Benefit Levels and Lifetime Maximum.

Rocky Mountain HCO's HCO-2004-SOLO-I-MSS-01-104 maternity supplement form in use during the examination period stated, in part the following:

MATERNITY SERVICES SUPPLEMENT

THIS MATERNITY SERVICES SUPPLEMENT is part of the SOLO Health Benefits Contract (Contract), *if purchased by the Subscriber upon payment of an additional Premium.*

1. Maternity Services: Maternity Services are Health Care Services under the Contract, *subject to the terms and conditions of this Maternity Services Supplement* and the Contract. Inpatient Maternity Services require Preauthorization by HCO.

. . .

Coverage for a hospital stay for a *newborn* and mother following a normal vaginal delivery will not be limited to less than forty-eight (48) hours, provided that if forty-eight (48) hours following delivery falls after 8:00 p.m., coverage shall continue until 8:00 a.m. the following morning. Coverage for a hospital stay for a *newborn* and mother following a cesarean section will not be limited to less than ninety-six (96) hours, provided that if ninety-six (96) hours following the cesarean section falls after 8:00 p.m., coverage shall continue until 8:00 a.m. the following morning. Notwithstanding the foregoing, a mother and newborn may be discharged prior to the foregoing minimum lengths of stay if the decision to discharge is made by an attending Physician with the agreement of the mother. [Emphases added.]

Form Name	Form Number	Edition Date
SOLO SELECT PPO HEALTH BENEFITS CONTRACT	HCO-2009-SOLOSELECT-I-HBC-01-109	2009
SOLO HEALTH BENEFITS CONTRACT, MATERNITY SERVICES SUPPLEMENT	HCO-2004-SOLO-I-MSS-01-104	2004

Recommendation No. 4:

Rocky Mountain HCO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S., during the examination period. In the event Rocky Mountain HCO is unable to

provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HCO shall be required within sixty (60) days from the date this report is adopted to provide written evidence to the Division that it has revised its contract forms to include the mandatory coverage provisions related to coverage for a hospital stay for dependent newborn children required by current Colorado insurance law. Additionally, the Company shall provide evidence that its individual contract forms and maternity services supplement forms, if used, clarify that coverage for a dependent newborn child will be provided according to current Colorado insurance law, even if the maternity services supplement is not added to the individual contract form. Within these sixty (60) days, Rocky Mountain HCO shall also provide the Division with specimen copies of all forms containing the revised provisions and related benefit schedules and provide the proposed date the forms will be put in use.

Issue E4: Failure of the Rocky Mountain HCO's forms, in some instances, to include all the required hospice care service benefits and provisions.

Section 10-16-104, C.R.S., Mandatory coverage provisions – definitions, states in part:

. . .

(8) Availability of hospice care coverage.

. . .

(b) Notwithstanding any other provision of law to the contrary, no individual or group policy of sickness or accident insurance issued by an insurer subject to the provisions of part 2 of this article and *no plan issued by an entity subject to the provisions of part 3 of this article which provides hospital, surgical, or major medical coverage on an expense incurred basis shall be sold in this state unless the policyholder under such policy is offered the opportunity to purchase coverage for benefits for the cost of home health service and hospice care* which have been recommended by a physician as medically necessary. . . .

. . .

(d) *The commissioner,* in consultation with the department of public health and environment, *may establish by rule and regulation requirements for standard policy and plan provisions which state clearly and completely the criteria for and extent of insured coverage for home health services and hospice care.* Such provisions shall be designed to facilitate prompt and informed decisions regarding patient placement and discharge. [Emphases added.]

Colorado Insurance Regulation 4-2-8, Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care, promulgated under the authority of §§ 10-1-109 and 10-16-104(8)(d), C.R.S., states in part:

. . .

Section 5 Requirements for Hospice Care

. . .

B. General Provisions Pertaining to Hospice Care.

1. The policy offering shall provide that hospice care services are to be covered when such services are provided under active management through a hospice which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished.

. . .

C. Benefits for Hospice Care Services.

. . .

2. The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by or through the hospice that are available to the insured will be negotiated at a hospice per diem rate with the hospice provider. *Any policy offered shall provide a benefit of no less than $100 per day for any combination of the following routine home care services,* which are planned, implemented and evaluated by the interdisciplinary team:

   (a) *Intermittent and 24 hour on-call professional nursing services provided by or under the supervision of a Registered Nurse;*

   (b) *Intermittent and 24 hour on-call social/counseling services: and;*

   (c) *Certified nurse aide services or nursing services delegated to other persons pursuant to § 12-38-132, C.R.S.*

   The total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days.

3. *The policy offering shall include the following benefits,* subject to the policy's deductible, coinsurance and stoploss provisions, *which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above:*

   (a) Bereavement support services for the family of the deceased person during the twelve month period following death, *and in no event shall this maximum benefit be less than $1150.*

   (b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer, provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer’s non-business hours if the hospice seeks the authorization during the insurer’s first business day;

   (c) Medical supplies;

   (d) *Drugs and biologicals*;

   (e) Prosthesis and orthopedic appliances;

   (f) *Oxygen and respiratory supplies*;

(g) *Diagnostic testing*;

(h) *Rental or purchase of durable equipment;*

(i) *Transportation*;

(j) *Physicians services*;

(k) Therapies including physical, occupational and speech; and

(l) Nutritional counseling by a nutritionist or dietitian.]

D. Limitations and Exclusions.

Benefits for hospice care services shall be governed by policy or certificate limitations and exclusions, *to the extent that such policy or certificate is not in conflict with the statutory mandate that hospice care be offered with the minimum benefits required by this regulation*. The insurer must notify the hospice in writing of any such limitation of benefits, and must do so within two business days of a request to determine if specific services are excluded or authorized under the coverage. [Emphases added.]

Rocky Mountain HCO was not in compliance with Colorado insurance law in that four (4) of its contract forms and two (2) of its coverage schedules in use during the examination period did not state clearly and completely the criteria for and the extent of the hospice benefits required to be provided pursuant to Colorado Insurance Regulation 4-2-8. The benefits emphasized above were either not specifically stated as hospice services benefits or the extent of a hospice services benefit was not included in these Rocky Mountain HCO forms, with some variance:

- The HCO's HCO-2009-VISTAPPO-G-EOC-01-709 contract form did not include the required statement that hospice care services provided under active management through a hospice responsible for coordinating all hospice care services are to be covered regardless of the location or facility in which such services are furnished.

- The HCO's HCO-2009-VISTAPPO-G-EOC-01-709 and HCO-2009-SOLOSELECT-I-HBC-01-109 did not include in its hospice benefits a benefit related to drugs and biologicals,

- Both of the coverage schedules stated the $100 minimum daily allowable amount related to the routine home care services applied to all hospice care benefits.

Rocky Mountain HCO's HCO-2009-VISTAPPO-G-EOC-01-709 contract form in use during the examination period stated in part, the following:

2. BENEFITS, LIMITATIONS AND EXCLUSIONS

. . .

B. Schedule of Health Care Services

. . .
14. Hospice Services

If You are terminally ill, hospice care is coordinated and certified by a Hospice. Benefits will be for services provided by a Hospice, Hospice Care Team, Hospital, Home Health Agency, or Skilled Nursing Facility for:

. . .

Hospice services and supplies must be provided under the terms of a Hospice Care Program and must be coordinated by the Hospice that manages that program. Benefits will be provided for:

- part-time and 24-hour on-call professional nursing services provided by or under the supervision of a registered nurse;
- part-time or intermittent home health aide services under the supervision of a registered nurse or specialized rehabilitative therapist;
- physical, occupational and pulmonary (respiratory or inhalation) therapy, subject to the limitations set forth in this Schedule of Health Care Services;
- speech therapy and audiology, subject to the limitations set forth in this Schedule of Health Care Services;
- nutritional counseling by a nutritionist or dietitian;
- intermittent and 24-hour on-call counseling and social services;
- Respite Care;
- medical supplies;
- prostheses and orthopedic appliances;
- short-term inpatient Hospice care or continuous home care for a period of crisis, pain control, acute intervention alternatives and chronic symptom-management; and
- bereavement support services for Your Immediate Family, Your primary care-giver and persons with close significant personal ties to You during the twelve-month period following death.

Rocky Mountain HCO.'s HCO-2009-SOLOSELECT-I-HBC-01-109 contract form in use during the examination period stated, in part, the following:

2. BENEFITS, LIMITATIONS AND EXCLUSIONS

. . .

B. Schedule of Health Care Services

. . .

18. Hospice Services

Benefits: Supportive and palliative care for a terminally ill Member is managed and coordinated by a Hospice, regardless of the location where services are provided, when approved by the Medical Director. Benefits shall be for services provided by a Hospice, Hospice Care Team, Hospital, Home Health Agency, or Skilled Nursing Facility for:

. . .

i) part-time and 24-hour on-call professional nursing services provided by or under the supervision of a registered nurse;
ii) part-time or intermittent home health aide services under the supervision of a registered nurse or specialized rehabilitative therapist;
iii) physical, occupational and pulmonary (respiratory or inhalation) therapy, subject to the limitations set forth in subparagraph 2.B(33);
iv) speech therapy and audiology, subject to the limitations set forth in subparagraph 2.B(33);
v) nutritional counseling by a nutritionist or dietitian;
vi) intermittent and 24-hour on-call social services;
vii) intermittent and 24-hour on-call counseling services;
viii) Respite Care;
ix) medical supplies;
x) prostheses and orthopedic appliances;
xi) short-term inpatient hospice care or continuous home care for a period of crisis, pain control, acute intervention alternatives and chronic symptom management when Preauthorized, except that Preauthorization is not required for such services in the event of a Medical Emergency, or on weekends, holidays or during RMHCO non-business hours; and
xii) bereavement support services for the Member's Immediate Family, the Member's primary care-giver and persons with close significant personal ties to the Member during the twelve-month period following the Member's death.

Rocky Mountain HCO's HCO-2009-SOLOSELECT-I-CS/2500D/3000M-01-109 and HCO-2009-SOLOSELECT-I-CS/2500D/3000M-02-709 coverage schedules, related to the HCO-2009-SOLOSELECT-I-HBC-01-109 contract form in use during the examination period, stated in part:

Health Care Service	In-Network Copayments and Coinsurance	Out-of-Network Copayment and Coinsurance
Hospice services – inpatient and outpatient Respite Care is limited to periods of five (5) days or less. *Maximum Benefit Level: $100.00 per Member per day payable by RMHCO.* [Emphasis added.]	After Deductible, 20% Coinsurance Coinsurance applies toward the Annual Out-of-Pocket Maximum	After Deductible, 40% Coinsurance Coinsurance applies toward the Annual Out-of-Pocket Maximum

Form Name	Form Number	Edition Date
ROCKY MOUNTAIN VISTA PREFERRED PROVIDER ORGANIZATION EVIDENCE OF COVERAGE	HCO-2009-VISTAPPO-G-EOC-01-709	2009
SOLO SELECT PPO HEALTH BENEFITS CONTRACT	HCO-2009-SOLOSELECT-I-HBC-01-109	2009
SOLO SELECT PPO HEALTH BENEFITS CONTRACT – COVERAGE SCHEDULE	HCO-2009-SOLOSELECT-I-CS/2500D/3000M-01-109	01/2009
SOLO SELECT PPO HEALTH BENEFITS CONTRACT – COVERAGE SCHEDULE	HCO-2009-SOLOSELECT-I-CS/2500D/3000M-02-709	07/2009

Recommendation No. 5:

Rocky Mountain HCO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-104, C.R.S., and Colorado Insurance Regulation 4-2-8 during the examination period. In the event Rocky Mountain HCO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HCO shall be required within sixty (60) days from the date this report is adopted to provide written evidence to the Division that it has revised its contract forms to state clearly and completely the criteria and the extent of coverage for the hospice care service benefits to comply with current Colorado insurance law. Additionally, Rocky Mountain HCO shall provide evidence that its contract forms, and related coverage schedules, do not apply the minimum daily allowable amount related to routine home care services to all hospice care benefits. Within these sixty (60) days, Rocky Mountain HCO shall also provide the Division with specimen copies of all forms containing the revised provisions and provide the proposed date the forms will be put in use.

NEW BUSINESS APPLICATIONS AND RENEWALS

Issue G1: Failure to require applicants for individual coverage to complete the determination of self-employed business groups of one and to provide disclosure forms with required information to these applicants.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

. . .

(v) Failure to comply with all provisions of section 10-16-108.5 concerning fair marketing of basic and standard health benefit plans, and section 10-16-105 concerning guaranteed issue of basic and standard health benefit plans;

Section 10-16-105.2, C.R.S., Small employer health insurance availability program, states in part:

(1) (c)(I) The provisions of this article concerning small employer carriers and small group plans *shall not apply to an individual health benefit plan newly issued to a business group of one* that includes only a self-employed person who has no employees, or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees, together with the dependents of such a self-employed person or sole proprietor *if, pursuant to rules adopted by the commissioner, all of the following conditions are met*:

(A) *As part of the application process, the carrier determines whether or not the applicant is a self-employed person who meets the definition of a business group of one* pursuant to section 10-16-102 (6).

(B) If the applicant is a business group of one self-employed person, the carrier accepts or rejects such person and, if such person is applying for family coverage, accepts or rejects the entire family unless the applicant waives coverage for a family member who has other coverage in effect.

(C) *If the carrier rejects an application for a business group of one self-employed person* and the carrier does business in both the individual and small group markets, *the carrier shall notify the applicant of the availability of coverage through the small group market and of the availability of small group coverage through the carrier*.

(D) *As part of its application form, an individual carrier requires a business group of one self-employed person purchasing an individual health benefit plan pursuant to this subparagraph (I) to read and sign a disclosure form* stating that, by purchasing an individual policy instead of a small group policy, such person gives up what would otherwise be his or her right to purchase a business group of one standard, basic, or other health benefit plan from a

> small employer carrier for a period of three years after the date the individual health benefit plan is purchased, unless a small employer carrier voluntarily permits such person to purchase a business group of one policy within such three-year period. *The disclosure form shall also briefly describe the factors used to set rates for the individual policy being purchased in comparison with the factors used to set rates for a business group of one small group policy. The individual carrier shall provide to the business group of one self-employed applicant a copy of the health benefit plan description form for the Colorado standard health benefit plan in addition to the description form for the individual plan being marketed.* The disclosure form may be included within any other certification form that the carrier uses for the plan. The division of insurance shall make available a standard plan description form to individual carriers upon request. [Emphases added.]

Section 10-16-108.5, C.R.S., Fair Marketing Standards, states in part:

> (1) Each small employer carrier shall actively market health benefit plan coverage, including the basic health benefit plan and the standard health benefit plan, to eligible small employers in the state.

Colorado Insurance Regulation 4-2-19, Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups of One, promulgated under §§ 10-1-109(1), 10-16-105.2(1)(c)(I) and (3), 10-16-108.5(8), and 10-16-109, C.R.S., states in part:

> . . .
>
> 5. Rules
>
> A. *An individual health benefit plan* marketed and/or newly issued on or after October 1, 2004, to a self-employed business group of one, together with the dependents of the self-employed business group of one, *shall be regulated as an individual health benefit plan* instead of a small group health plan *if the carrier issuing such policy, the policy itself, and the application for coverage meet all the following conditions:*
>
> 1. Pursuant to Section 10-16-105.2(1)(c)(I)(A), C.R.S., *the carrier issuing the policy determines whether or not the applicant is a self-employed business group of one. A carrier shall meet this requirement by having all applicants fill out the "Determination of Self-Employed Business Group of One Form"* available from the Colorado Division of Insurance. *A copy of the completed form shall be kept on file with each application.* In addition, pursuant to Section10-16-102(6)(c), C.R.S., a carrier may require all business group of one applicants to supply certain tax and withholding documents in order to determine if an applicant meets the definition of a business group of one. Applicants who answer "yes" to all the questions in the form and, if required by the carrier, who can document their answers shall be considered to have met the test of a self-

employed business group of one. An applicant who does not meet this test falls into one of two categories. Either:

a) The applicant is a small employer that is not a self-employed business group of one and thus any plan sold to such person is subject to the small group laws of Colorado, pursuant to Section 10-16-105.2(1)(a), C.R.S.; or

b) The applicant is neither a small employer, nor a self-employed business group of one, nor any other person covered by the small group laws of Colorado (see Section 10-16-105.2(1), C.R.S.) and thus any plan sold to such person is not subject to this regulation but is subject to the other laws of Colorado relating to individual health benefit plans.

. . .

3. If, pursuant to Section 5.A.2 of this regulation, *a carrier rejects an application by a self-employed business group of one for coverage under an individual health benefit plan,* and if that same carrier sells coverage in both the individual and small group markets, then pursuant to Section 10-16-105.2(1)(c)(I)(C), C.R.S., *the carrier notifies the applicant of the availability of small group coverage both through the small group market and through the carrier. The notice shall inform the applicant of his/her guarantee issue rights as detailed in Section 10-16-105(7.3)(a) and (c), C.R.S. This notice shall be in writing and shall be included as part of the denial of individual coverage letter. A copy of the denial letter and the notice concerning the availability of small group coverage shall be maintained by the carrier in the file with the original application.*

4. A carrier issuing an individual health benefit plan to a self-employed business group of one shall abide by the disclosure requirements as described in Section 10-16-105.2(1)(c)(I)(D), C.R.S. Accordingly:

   a) *The carrier, as part of its application form, shall require each self-employed business group of one purchasing an individual health benefit plan pursuant to Section 10-16-105.2(1)(c)(I), C.R.S., to read and sign a disclosure form, as proscribed by the Division of Insurance, attesting that they understand that they are forfeiting their rights to purchase a business group of one standard, basic, or other health benefit plan from a small employer carrier for a period of three (3) years after the date of purchase,* unless a small employer carrier voluntarily permits the purchase of a business group of one policy within that three-year period.

   b) The carrier must provide the applicant with a Colorado Health Benefit Plan Description Form for the state's Standard Health Benefit Plans, available from the Colorado Division of Insurance. Carriers may reproduce and distribute this form in order to comply with the

provisions of Section 10-16-105.2(1)(c)(I)(D), C.R.S. [Emphases added.]

Bulletin No. B-4.7, Determination of Self-Employed Business Groups of One Form and Disclosure Form for Self-Employed Business Groups of One Applying for Individual Health Benefit Plans, reissued May 8, 2007, states in part:

. . .

III. Division Position

Existing law requires an individual carrier to have all applicants complete the "Determination of Self-Employed Business Group of One Form" prior to the issuance of an individual policy. The bulletin provides the required form in Appendix A.

In addition, existing law requires an individual carrier, as part of its application form, to obtain a signed disclosure from a self-employed business group of one that is applying for an individual health benefit plan. The form shall include the following statements:

"Please read and sign the following disclosure required by Colorado law:

I, (name of applicant), meet the definition of a self-employed business group of one as attested to on the accompanying Determination of Self-Employed Business Group of One Form. I understand that by purchasing an individual policy instead of a small group policy, I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three (3) year period.

I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of [NOTE: CARRIERS ENTER FACTORS HERE]. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited to plan design, the carrier's overall cost and utilization trends ("index rate"), my age, my family size, a factor that reflects the cost of care where I live, health status, claims experience, standard industrial classification and/or tobacco use.

I have been given a health plan description form showing the benefits under Colorado's small group Standard Health Benefit Plans. I have also been given a Colorado Health Plan Description Form for the plan for which I am applying."

Rocky Mountain HCO was not in compliance with Colorado insurance law in that it failed to obtain, have signed, and maintain with the application for individual health coverage, required questions and disclosure forms related to qualified self-employed business groups of one. Colorado insurance law requires the completion of the "Determination of Self-Employed Business Group of One Form"

(Determination) and with it a disclosure form as part of the application process for an individual policy. The Determination and, when applicable, the disclosure form must be signed by the applicant.

The examiners reviewed 228 individual health applications received in 2009. None of the files contained the required Determination or signed disclosure forms or any other evidence that they had been provided or completed. In addition, 115 applications were approved and issued without evidence that the applicants completed the Determination. It is therefore unknown whether any applicant qualified as a business group of one, and should have been advised of the availability of group coverage, the penalty for obtaining individual coverage instead of group coverage, and the factors used in rating the individual plan and group plans. Also, 113 applicants were declined without evidence that the Determination had been completed. It is therefore unknown whether any applicant was eligible and when rejected for coverage under an individual plan, should have been given notice of the availability of group coverage.

Rocky Mountain HCO's application forms did, in some instance, include information advising the applicant who believed he or she was a business group of one that he or she was not eligible for an individual plan, but provided no information to the applicant to help make that determination. The Company is required to ask the specific questions in the Determination and from the answers make a determination of eligibility rather than relying upon the individual to know and report such eligibility.

Rocky Mountain HCO has stated that, because it does not market or issue individual plans to self-employed business groups of one it is not required to have individual applicants complete and sign the Determination. The requirement for having applicants complete the Determination is not contingent upon whether the Company markets or intends to issue an individual plan to a self-employed business group of one. The purpose of the Determination is to find out whether the applicant is a self-employed business group of one and, if so, to provide the required disclosures for the applicant's signature.

Rocky Mountain HCO likely cannot know, before the applicant completes the Determination, whether the applicant is a self-employed business group of one. Unless the applicant completes the Determination, the applicant may not know either. The Company can't be sure that when an applicant doesn't indicate to the Company that such individual is a self-employed business group of one, doesn't withdraw the application and doesn't request an application for a business group of one plan that the reason is because such individual is not a self-employed business group of one.

As a result, Rocky Mountain HCO was not providing the disclosure form explaining that the applicant was giving up the right to purchase group coverage for three years by the purchase of an individual plan. The Company may also have failed to meet other requirements such as providing the required health plan description forms for both the standard health benefit plan and the individual plan being marketed, the descriptions of the factors used in setting the rates for the individual plan as compared to the factors used to set rates for a business group of one, and declination requirements.

Because Rocky Mountain HCO inappropriately relied upon knowledge and understanding of the definition of a self-employed business group of one that an individual applicant may not have had, the Company may have issued or declined to issue individual coverage to an applicant that was a qualified self-employed business group of one.

In addition, by failing to require the completion of the Determination and, as applicable, the disclosure form, Rocky Mountain HCO may have caused a self-employed business group of one to give up valid rights without knowing what those rights were or that they were being relinquished.

Recommendation No. 6:

Rocky Mountain HCO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of §§ 10-3-1104, 10-16-105.2 and 10-16-108.5, C.R.S., and Colorado Insurance Regulation 4-2-19 during the examination period. In the event Rocky Mountain HCO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HCO shall be required within sixty (60) days from the date this report is adopted to provide written evidence to the Division that it has revised its individual application process to include requiring completion of the Determination of Self-Employed Business Groups of One Form and, when applicable, the Disclosure Form for Self-Employed Business Groups of One Applying for Individual Health Benefit Plans to comply with current Colorado insurance law. Within these sixty (60) days, Rocky Mountain HCO shall also provide the Division with specimen copies of all forms containing the revised provisions and provide the proposed date the forms will be put in use.

CLAIMS

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt Payment of Claims – legislative declaration, states in part:

. . .

(2) *As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents.* A claim requiring additional information shall not be considered a clean claim and shall be paid, denied or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean Claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

. . .

(4) (a) *Clean claims shall be paid, denied, or settled* within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.*

(5) (a) *A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the*

claim, accruing from the date payment was due pursuant to subsection (4) of this section.

The examiners selected a random sample of 109 claims from a population of 21,501 electronic claims paid, denied or settled more than thirty (30) days after receipt by Rocky Mountain HCO during the examination period. Rocky Mountain HCO was not in compliance with Colorado insurance law in that sixty-one (61) of the 109 claims were clean claims that were not paid, denied or settled within thirty (30) days.

ELECTRONIC CLAIMS PROCESSED OVER 30 DAYS - LATE

Population	Sample Size	Number of Exceptions	Total Error Percent
21,501*	109	61	56%

(*6% of all claims)

The examiners randomly selected 109 claims from a population of 8,994 electronic and nonelectronic claims paid, denied, or settled more than ninety (90) days after receipt during the examination period. Rocky Mountain HCO was not in compliance with Colorado insurance law in that ten (10) of the 109 claims reviewed were not paid, denied or settled within ninety (90) days. There was no indication of fraud and the examiners found no evidence of a fraud investigation in the files. Errors in Rocky Mountain HCO's earlier processing of those ten (10) claims required re-adjudication of those claims, causing the final adjudication to be late, under Colorado insurance law.

CLAIMS PROCESSED OVER 90 DAYS - LATE

Population	Sample Size	Number of Exceptions	Total Error Percent
8,994*	109	10	9%

(*2% of all claims)

Recommendation No. 7:

Rocky Mountain HCO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S., during the examination period. In the event Rocky Mountain HCO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HCO shall be required within thirty (30) days from the date this report is adopted to provide written evidence to the Division that it has reviewed and modified its claims processing and quality controls to ensure that all claims are adjudicated within the time periods required by Colorado insurance law.

Issue J2: Failure, in some cases, to pay interest or penalty owed on claims not paid, denied or settled timely, as required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt Payment of Claims – legislative declaration, states in part:

. . .

(4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically* and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.*

. . .

(5) (a) *A carrier that fails to pay, deny or settle a claim in accordance with paragraph (a) of subsection (4) of this section* or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, *shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.*

(b) *A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to twenty percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.* If a carrier denies a claim in accordance with subsection (4) of this section within ninety days after receiving the claim and the denial is determined to be unreasonable pursuant a civil action in accordance with section 10-3-1116, the carrier shall pay the

> penalty in this paragraph (b) to the insured or to the assignee. [Emphases added.]

The examiners selected a random sample of109 claims from a population of 21,501 electronic claims paid, denied or settled more than thirty (30) days after Rocky Mountain HCO received them. Rocky Mountain HCO was not in compliance with Colorado insurance law in that fifteen (15) of those 109 claims were clean claims that were paid late for which interest was owed but not paid.

ELECTRONIC CLAIMS PROCESSED OVER 30 DAYS - INTEREST

Population	Sample Size	Number of Exceptions	Total Error Percent
21,501*	109	15	14%

(*6% of all claims)

The examiners selected a random sample of 109 claims from a population of 8,994 electronic and nonelectronic claims paid, denied, or settled more than ninety (90) days after Rocky Mountain HCO received them. Rocky Mountain HCO was not in compliance with Colorado insurance law in that for ten (10) of the 109 claims a penalty was owed but was not paid.

CLAIMS PROCESSED OVER 90 DAYS - PENALTY

Population	Sample Size	Number of Exceptions	Total Error Percent
8,994*	109	10	9%

(*2% of all claims)

Recommendation No. 8:

Rocky Mountain HCO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S., during the examination period. In the event Rocky Mountain HCO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HCO shall be required within thirty (30) days from the date this report is adopted to provide written evidence to the Division that it has initiated changes to its claims processing procedures to ensure that interest or penalty is paid when owed for all claims that are not paid, denied or settled within the time frames required by Colorado insurance law.

Issue J3: Failure, in some cases, to comply with Colorado insurance law regarding written explanations of what additional information is needed to determine liability and adjudicate a claim.

Section 10-16-106.5, C.R.S., Prompt Payment of Claims – legislative declaration, states in part:

. . .

(4) (b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

. . .

(5) (a) A c*arrier that fails to* pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or *take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.* [Emphases added.]

Colorado Insurance Regulation 4-2-24, Concerning Clean Claim Requirements for Health Carriers, promulgated under the authority of §§ 10-16-106.3(2), 10-16-109, and 10-1-109, C.R.S., states in part:

. . .

Section 6. Additional Information

A. A claim with all required fields is not considered "clean" if additional information is needed in order to adjudicate the claim. Carrier may request additional information only if the carrier's claim liability cannot be determined with the existing information on the claim form and the information requested is likely to allow a determination of liability to be made. *When additional information is required the carrier shall make the specific request in writing within thirty calendar days after receipt of the claim form.* If information is being requested from a party other than

the billing provider, the provider shall be notified that additional information is needed to adjudicate the claim. *The specific information requested shall be requested within 30 calendar days after receipt of the clam form and identified for the provider upon request.*

. . .

F. When requesting medical records, carriers must identify the particular components(s) of the medical record being requested or indicate the specific reason for the request, e.g., progress reports for most recent three months, or records to establish the medical necessity of the treatment provided. The records requested must be related to the service/procedure of the claim and limited to the minimum amount of information necessary. *Requests for "all medical records" are not specific enough and would not be an appropriate request for claim adjudication.* [Emphases added.]

Rocky Mountain HCO, in some cases, was not in compliance with Colorado insurance law in its requests for additional information required to adjudicate the claims (pending letters).

Rocky Mountain HCO used two pending letter forms requesting information regarding potential pre-existing conditions during the examination period; one was for members and the other was for providers. The pending letters were not in compliance with Colorado insurance law in that the letters requested information on *all* health care services rendered to the member over a period of months. Carriers may request only records related to the service/procedure of the claim. The information which may be requested is limited to the minimum amount of information necessary to adjudicate the claim.

The member pending letter Rocky Mountain HCO used during the examination period, CLM49R0608, stated in part:

. . .

. . . We will need information about the health care services you received on (date), **and** all health care services that have been rendered between (date) and (date).

If you cannot provide a Certificate of Creditable Coverage for this time period, please complete the statements below and return your response to RMHP by (date). **If a complete response is not returned by this date, claims related to treatment of medical conditions you experienced during the time period noted above may be denied by RMHP.**

Describe all MEDICAL CONDITIONS for which (name of Member) sought services between (date) and (date):

List all MEDICATIONS that have been prescribed or refilled for (name of Member) between (date) and (date):

List all NAMES and PHONE NUMBERS of PHYSICIANS (Name of Member) saw between (date) and (date):

> List all ADVICE and TREATMENT PLANS given to (Name of Member) by a physician between (date) and (date): [Emphases original.]

The provider pending letter Rocky Mountain HCO used during the examination period, CLP65, stated in part:

> . . .
>
> Rocky Mountain Health Plans (RMHP) has received a claim for (Member Name), Date of Birth (date of birth). RMHP is unable to process this claim because the services may be subject to a pre-existing condition period. *In order to determine if the services are excluded by a pre-existing condition, RMHP is requesting copies of all medical records (including office visits, consults, x-rays, diagnostic testing, medication list and problems list) for this member from (date) to(date), if available.*

The examiners selected a random sample of 109 electronic claims from the population of 21,501 electronic claims adjudicated more than thirty (30) days after receipt. Of those, twelve (12) were unclean claims that needed pending letters sent to request additional information needed to adjudicate the claims. In some instances, the examiners determined Rocky Mountain HCO was not in compliance with Colorado insurance law for eight (8) claims in that:

- Two (2) claims had no pending letters sent after receipt of the specific claim.
- One (1) claim had the pending letter sent late, more than thirty (30) days after receipt of the claim, and the pending letter requested all medical records, and
- Five (5) claims had pending letters that requested all medical records.

ELECTRONIC CLAIMS OVER 30 DAYS – PENDING PRACTICES

Population	Sample Size	Claims in Sample Needing Information	Number of Exceptions	Total Error Percent
21,501*	109	12	8	67%

(*6% of all claims)

Colorado insurance law requires carriers to request additional information needed to adjudicate a claim within thirty (30) calendar days after receipt of the claim; to make such request in writing; and to include a full explanation in the request of what is needed to resolve the claim. Colorado insurance law also requires carriers to be specific as to what information is required to adjudicate the claim, to limit requests for medical records to the minimum amount of information necessary and provides that requests for "all medical records" are not specific enough and are not appropriate requests for claim adjudication.

Recommendation No. 9:

Rocky Mountain HCO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S., and Colorado Insurance Regulation 4-2-24 during the examination period. In the event Rocky Mountain HCO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HCO shall be required within thirty (30) days from the date this report is adopted to provide written evidence to the Division that is has revised its claims procedures to ensure written requests for information are sent within thirty (30) days of receipt of a claim and the requests are in compliance with Colorado insurance law.

Issue J4: Failure to adopt and implement reasonable standards for prompt investigation of claims including refusing to pay claims or retracting claims payments without conducting a reasonable investigation of all available information.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> . . .
>
> (h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:
>
> . . .
>
> (III) *Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; or*
>
> (IV) *Refusing to pay claims without conducting a reasonable investigation based upon all available information, or*
>
> . . .
>
> (VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; or [Emphases added.]

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

> . . .
>
> (4) (b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim,* including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, *the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b*), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, *all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphases added.]

Colorado Insurance Regulation 4-2-24, Concerning Clean Claim Requirements for Health Carriers, promulgated under the authority of §§ 10-16-106.3(2), 10-16-109, and 10-1-109, C.R.S., states in part:

. . .

Section 6 Additional Information

A. *A claim with all required fields completed is not considered "clean" if additional information is needed in order to adjudicate the claim.* Carriers may request additional information only if the carrier's claim liability cannot be determined with the existing information on the claim form and the information requested is likely to allow a determination of liability to be made. *When additional information is required the carrier shall make the specific request in writing within thirty calendar days after receipt of the claim form*. If information is being requested from a party other than the billing provider, the provider shall be notified that additional information is needed to adjudicate the claim. *The specific information requested shall be requested within 30 calendars days after receipt of the claim form and identified for the provider upon request.*

B. Additional information requested must be related to information in the required fields of the claim forms, although the genesis of the request may be from other sources . . . [Emphases added.]

Colorado Insurance Regulation 4-6-2, Group Coordination of Benefits, promulgated under the authority of §§ 10-1-109, and 10-16-109, C.R.S., states in part:

. . .

Section 4. Definitions

. . .

H. "Plan" means a form of coverage with which coordination is allowed or required. . . .

. . .

(3) "Plan" may include:

. . .

(g) The medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts; and

. . .

J. "Secondary plan" means a plan that is not a primary plan. . . .

K. "This plan" means, in a COB provision, the part of the group contract providing health care benefits . . . which may be reduced because of the benefits of other plans. . . .

. . .

Section 6. Rules for Coordination of Benefits

. . .

C. A plan may consider the benefits paid or provided by another plan only when it is secondary to that other plan.

. . .

Section 7. Procedure to be Followed by Secondary Plan

A. (1) . . . As each claim is submitted, the secondary plan must:

(a) Determine its obligation, pursuant to its contract;

. . .

(c) Determine whether there are any unpaid allowable expenses during that claim determination period.

. . .

B. *The benefits of the secondary plan shall be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan* in the absence of this COB provision *and the benefits that would be payable for the allowable expenses under the other plans,* in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, *exceeds the allowable expenses in a claim determination period.* In that case, the benefits of the secondary plan shall be reduced so that they and the benefits payable under the other plans do not total more than the allowable expenses.

. . .

Section 9. Miscellaneous Provisions

A. *A secondary plan* that provides benefits in the form of services *may recover* the reasonable cash value of the services from the primary plan, *to the extent that benefits* for the services are covered by the primary plan and *have not already been paid by the primary plan*.

> B. (1) A plan with order of benefit determination rules that comply with this regulation (complying plan) may coordinate it benefits . . . on the following basis:
>
> . . .
>
> (2) If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than he or she would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to or on behalf of the covered person an amount equal to the difference.
>
> (3) . . . In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the noncomplying plan. . . .[Emphases added.]

Rocky Mountain HCO was not in compliance with Colorado insurance law in that its claims standards included paying or denying a claim, in some cases, without conducting a reasonable investigation to determine the Company's claim liability.

When a claim was submitted with an indicator code showing it was employment related, the claim was denied without determining whether the treatment or procedure actually was covered by workers compensation coverage. When a claim was submitted with an indicator code showing it was auto accident related, the claim was denied without determining whether auto medical payments coverage was applicable to the treatment or procedure on the date of service it was provided.

Rocky Mountain HCO included an explanation of this procedure for claims handling in the document "RMHP's Third Party Liability Case Development and Research":

> . . .
>
> When an individual claim is submitted with a clear indication (this indication is the use of an "employment" indicator code) from the provider that the services provided are work related, that claim will be denied, as services such as these are not a benefit of RMHP's plans.
>
> When an individual claim is submitted with a clear indication (this indication is the use of an "auto accident") from the provider that the services provided are automobile (auto) related, that claim will be denied, as auto medical payments coverage is primary over RMHP coverage.

Colorado insurance law requires carriers to conduct a reasonable investigation before denying a claim. Any procedure that allows denying a claim without a reasonable investigation is not in compliance with Colorado insurance law.

In addition to denying and, in some cases, paying claims without investigation, one part of the claims standards Rocky Mountain HCO adopted and implemented was the use of My Socrates Third Party Liability (TPL) investigation software. My Socrates software was built with rules based on diagnosis codes that the developers believed depicted the likelihood of an injury or an accident and the possibility that a third party may be liable. Claims that were finalized (paid or denied) were extracted and, in some

cases, identified and imported by My Socrates investigation software. A case file of those claims was created by My Socrates investigation software and all claims Rocky Mountain HCO received for that member from that point forward were appended to the case file regardless of diagnosis code. However, non-injury related claims data were housed in the "inactive" section of the case, whereas the injury related claims data were housed in the "active" section of the case. Whether a claim was injury related was determined by the diagnosis codes in the My Socrates rules that were the basis for the creation of the case file.

When Rocky Mountain HCO's amount paid for claims with the diagnosis code identified in the My Socrates rules reached a threshold of $500, a financial recovery team member conducted a TPL investigation to determine the identity of any third party potentially liable for the claims included in the case file.

In some cases, initial claims adjustment decisions of "finalized" claims were reversed when the TPL information was received. Claims Rocky Mountain HCO denied without first conducting reasonable investigations were, in some cases, paid because the Company learned there was no applicable third party involved and the denials were in error. Claims paid without investigations were retracted, in some cases, when Rocky Mountain HCO's TPL investigation revealed that a third party was or had been involved in the claim or similar claims.

The retractions of payments, in some cases, were made without Rocky Mountain HCO first determining whether the third party identified had also paid the claims which Rocky Mountain HCO had paid, making the Rocky Mountain HCO payment a duplicate. Unless there was an overpayment via a duplicate payment, retracting the payment was not in compliance with Colorado insurance law.

The Company's Claims Processing Manual in the section titled "COB and TPL", states in part:

> Effective 11/2008, RMHP successfully implemented a new remediation process that will be supported by My Socrates, Inc. effective 12/2008. With new legislation, RMHP historical process of pursuing third parties before paying claims was converted to a pay-then-pursue process of claims review.
>
> The TP32 and TP60 claims pend process became obsolete and all claims review is done behind the scenes from the normal claims examining functions.

Rocky Mountain HCO explained that the statement in the Company's Claims Processing Manual that the claims "pend process" for certain claims (TP32 and TP60) became obsolete and "all claims review is done behind the scenes" referred to the TPL investigation process as opposed to the normal claims payment criteria review. However, requests for retraction of claims or to "pick up" and pay claims, in some cases, had "TPL" as the contact and included the notation "TPL review completed - Yes". The retracted claims, in some cases, were later adjusted a second time to correct the first adjustment the TPL team requested. This occurred, in some cases, because Rocky Mountain HCO processed the first TPL requests without investigating to determine whether there had been a duplicate payment before retracting the payment.

Rocky Mountain HCO s Third Party Liability Case Development and Research document stated that the financial recovery team focused on TPL investigations and did not review claims or make individual claims payment decisions. Rocky Mountain HCO stated that was correct. Nevertheless, the financial recovery team, TPL, requested adjustments to claims. Those adjustment requests and subsequent adjustments without further investigation indicated the TPL investigation results were integrated with the

overall claims investigation and adjustment process.

Rocky Mountain HCO substituted its pay then pursue process of claims review, initiated after claims with certain diagnosis codes were originally "finalized", for the required initial investigations of claims. This was true for claims denied when submitted with employment or auto accident related indicators and for claims paid as indicated in Rocky Mountain HCO's claims manual. The examiners observed the TPL process was an active part of the process Rocky Mountain HCO adopted and implemented for claims investigation and resolution. That process included a standard of paying or denying claims without first conducting reasonable investigations.

Recommendation No. 10:

Rocky Mountain HCO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of §§ 10-3-1104 and 10-16-106.5, C.R.S., and Colorado Insurance Regulations 4-2-24 and 4-6-2 during the examination period. In the event Rocky Mountain HCO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HCO shall be required within thirty (30) days from the date this report is adopted to provide written evidence to the Division that is has revised its claims procedures to require completion of a reasonable investigation to determine liability before denying a claim or retracting a claim payment. Within these thirty (30) days, Rocky Mountain HCO shall also provide the Division with copies of any claims guidelines and TPL investigation guidelines revised to comply with Colorado insurance law.

Issue J5: Failure to correctly count the number of days to pay or deny claims and determine whether the claim was adjudicated late and/or interest was owed.

Section 10-16-106.5, C.R.S., Prompt Payment of Claims – legislative declaration, states in part:

. . .

(4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.*

(b) *If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim.* The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.*

. . .

(5) (a) *A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.*

(b) *A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to twenty percent of the total amount ultimately allowed on the claim.* Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier. If a carrier denies a claim in accordance with subsection (4) of this section within ninety days after receiving the claim and the denial is determined to be unreasonable pursuant

> a civil action in accordance with section 10-3-1116, the carrier shall pay the penalty in this paragraph (b) to the insured or to the assignee. [Emphases added.]

In some cases, Rocky Mountain HCO was not in compliance with Colorado insurance law in that its process for determining the date a claim is paid for the purpose of determining whether a claim is paid timely did not properly count the number of days to pay or deny the claim.

Rocky Mountain HCO calculated the number of days to pay from the date the check was issued or printed rather than the date the check was mailed. The Company's usual process was to accumulate all claims payments authorized during the week into a batch run that began on Friday night and ran through some time on Saturday. The checks that ran in that batch were then mailed the following Monday along with vouchers/remittances sent to providers and explanations of benefits sent to members. Rocky Mountain HCO built one day into its counting process to reflect that the batch run began on Friday finished on Saturday. Its records showed the claims paid on Saturday.

Because the claims checks were mailed on the following Monday, Rocky Mountain HCO's process should have built in a total of three days from the date the batch began to run to accurately record the date the checks were mailed. In addition, no adjustment was made to the number of days added in the counting process for holidays that occurred on Mondays, Fridays, or Saturdays. That also impacted either the day the batch run began or the day the checks were mailed, or both.

Accurately counting and recording the number of days to pay claims is material to determining whether claims are paid timely or not and whether interest or penalty is owed on claims payments as well as the amount of interest when it is owed.

Recommendation No. 11:

Rocky Mountain HCO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-106.5, C.R.S., during the examination period. In the event Rocky Mountain HCO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HCO shall be required within thirty (30) days from the date this report is adopted to provide written evidence to the Division that it has revised its systems and procedures to ensure that the number of days to adjudicate claims and the amount of interest or penalty owed in the case of a late payment is calculated correctly as required by Colorado insurance law.

UTILIZATION REVIEW

Issue K1: Failure to include the qualifying credentials of the physician or clinical peer who evaluated the appeal in the written notification of the decision.

Section 10-16-113, C.R.S., Procedure for denial of benefits – internal review – rules, states in part:

. . .

(3)(b)(V) The first-level appeal shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer; . . .

Colorado Insurance Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits, promulgated under the authority of § 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b) and 10-16-109, Colorado Revised Statutes (C.R.S.), states in part:

. . .

Section 4. Definitions

D. *"Clinical peer" means a physician or other health care professional who holds* a non-restricted license in a state of the United States and *in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.* [Emphasis added.]

. . .

Section 10. First Level Review

. . .

G. Notification Requirements

1. A health carrier shall notify and issue a decision in writing or electronically to the covered person within the time frame provided in Paragraph 2. or 3.

. . .

I. The decision issued pursuant to Subsection G. shall set forth in a manner calculated to be understood by the covered person:

1. The name, title and *qualifying credentials* of the physician evaluating the appeal, and the *qualifying credentials* of the clinical peer(s) with whom the physician consults. . . .[Emphases added.]

The examiners reviewed the entire population of ten (10) first level appeals cases received during the examination period. In seven (7) of these cases, Rocky Mountain HCO was not in compliance with Colorado insurance law in that it failed, in the written notification letter, to provide the qualifying credentials of the physician and clinical peer(s) who evaluated the first level review.

FIRST LEVEL APPEALS – QUALIFYING CREDENTIALS

Population	Sample	Number of Exceptions	Total Error Percent
10	10	7	70%

Recommendation No. 12:

Rocky Mountain HCO shall be afforded a reasonable period, not exceeding thirty (30) days from the date of this report, to make written submission or rebuttal as to why it should not be considered in violation of § 10-16-113, C.R.S., and Colorado Insurance Regulation 4-2-17 during the examination period**.** In the event Rocky Mountain HCO is unable to provide such documentation, the Company may include, with its submission or rebuttal, its plan to comply, or evidence that it is now in compliance.

Otherwise, Rocky Mountain HCO shall be required within thirty (30) days from the date this report is adopted to provide written evidence to the Division that it has revised its first-level appeal notification letters to include the qualifying credentials of the physician and clinical peer(s) as required by Colorado insurance law**.**

SUMMARY OF ISSUES AND RECOMMENDATIONS	Rec. No.	Page No.
OPERATIONS AND MANAGEMENT		
Issue A1: Failure to ensure that all forms certified and used by Rocky Mountain HCO during the examination period were in compliance with Colorado insurance law.	1	22
FORMS		
Issue E1: Failure of the Company's certificate of creditable coverage forms, in some instances, to include required information. ***(This was a partial repeat of prior issue H2 in the findings of the market conduct examination report for 2004).***	2	24
Issue E2: Failure of the Company's basic and standard health benefit plan forms, in some instances, to include the required "Family Planning Service" benefit for treatment and screening of sexually transmitted diseases within the schedule of health care services.	3	31
Issue E3: Failure of the Company's forms, in some instances, to include the mandatory coverage provisions related to a hospital stay for dependent newborn children following birth.	4	33
Issue E4: Failure of the Rocky Mountain HCO's forms, in some instances, to include all the required hospice care service benefits and provisions.	5	40
NEW BUSINESS APPLICATIONS AND RENEWALS		
Issue G1: Failure to require applicants for individual coverage to complete the determination of self-employed business groups of one and to provide disclosure forms with required information to these applicants.	6	47
CLAIMS		
Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time periods required by Colorado insurance law.	7	50
Issue J2: Failure, in some cases, to pay interest or penalty owed on claims not paid, denied or settled timely, as required by Colorado insurance law.	8	52
Issue J3: Failure, in some cases, to comply with Colorado insurance law regarding written explanations of what additional information is needed to determine liability and adjudicate a claim.	9	55
Issue J4: Failure to adopt and implement reasonable standards for prompt investigation of claims including refusing to pay claims or retracting claims payments without conducting a reasonable investigation of all available information.	10	62
Issue J5: Failure to correctly count the number of days to pay or deny claims and determine whether the claim was adjudicated late and/or interest was owed.	11	64

UTILIZATION REVIEW		
Issue K1: Failure to include the qualifying credentials of the physician or clinical peer who evaluated the appeal in the written notification of the decision.	12	67

Examination Report Submission

State Market Conduct Examiners

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC
Examiner-in-Charge

Violetta R. Pinkerton, CIE, MCM, CPCU, CPIW
Lead On-site Examiner

Damion Hughes

And

Independent Contract Examiners

Larry E. Cross, CIE

Jay E. Hodges, CIE, ALHC, HIA

Yvonne Sainsbury, AIE

Submit this report on this 27th day of September, 2012 to:

The Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202